Mirabile M.D.
BEAUTY, HEALTH & WELLNESS

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Female History & Symptoms

Name: _____ Date of Birth: _____Today's Date: _____

Gynecology History

Do you have pain with intercourse? □ Yes □ No
Date of last mammogram: _____ Date of last pap smear: _____
Have you ever had an abnormal pap smear? □ Yes □ No
Do you have trouble with leaking urine? □ Yes □ No
Number of total pregnancy's: _____ Number of live births: _____

Menstrual History

Do you still have periods? □ Yes □ No
If no, please check reason:
□ Natural □ Hysterectomy □ Ablation □ Menopause (If menopausal, at what age did it start? ____)

Medical History

Do you or any close family members (mother/father, sibling, grandparent, aunt/uncle) have history of any of the following? Check all that apply.

Condition	Self		Family Member	
Hypertension	□	How treated: _____	□	Relationship: _____
Breast Cancer	□	How treated: _____	□	Relationship: _____
Diabetes	□	How treated: _____	□	Relationship: _____
Colon Cancer	□	How treated: _____	□	Relationship: _____
Ovarian Cancer	□	How treated: _____	□	Relationship: _____
Uterine Cancer	□	How treated: _____	□	Relationship: _____
Osteoporosis	□	How treated: _____	□	Relationship: _____
Heart Disease	□	How treated: _____	□	Relationship: _____
Stroke	□	How treated: _____	□	Relationship: _____
Bleeding Disorder	□	How treated: _____	□	Relationship: _____
Thyroid Disease	□	How treated: _____	□	Relationship: _____
Other: _____	□	How treated: _____	□	Relationship: _____

List any surgeries and/or hospitalizations: _____
_____
List any known drug allergies: _____
List any medications currently taking and dosage, including hormone replacement therapy: _____
_____
_____
Family Physician/Practice: _____ Phone number: _____
Pharmacy: _____ Phone number: _____

_____ Mirabile M.D. is not responsible for omissions of medical & medication information.
Please initial